STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005075	A. BUILDING _____ B. WING _____	07/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT HOSPITAL & HEALTH SERVICES	2001 W 86TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for 1 (one) State hospital complaint investigation. Complaint: #IN00085662 Unsubstantiated; lack of sufficient evidence. Facility: #005075 Date: 7-1-2011 Surveyor: Karilyn M. Tretter, RN Public Health Nurse Surveyor St. Vincent Hospital & Health Services (Stress Center) is in compliance with 410 IAC 15-1.6.5, Psychiatric services and 410 IAC 15-1.5-5, Physician services, Indiana State Hospital Licensure Rules. QA: claughlin 08/04/11	S 000		